White House Conference on Aging: Solutions Forum on Rural Aging

Good afternoon. My name is Cecil Pollard and for the past twenty-five years I have been the Director of the Office of Health Services Research at West Virginia University, Department of Community Medicine. During my tenure at West Virginia University I have had the unique experience of working with many of the rural providers throughout West Virginia. This work experience has permitted me and my office staff to contribute to the improvement of health and social services for the rural elderly. Our initial challenge was to assist rural towns in developing community health centers. We did this by providing technical assistance in seeking funding, recruiting providers, completing epidemiological and manpower studies, and assessing medical service needs. Together with our partners in the West Virginia Bureau of Primary Care, the federal Bureau for Primary Care, the Claude Worthington Benedum Foundation, the West Virginia Primary Care Association, and many others, we now have over 80 community health centers in the state.

These community health centers are a significant component of the health care system in West Virginia. Combined, these centers provide health care to over 200,000 underserved, rural West Virginians. For many of our rural elderly these community health centers are the only health care available.

In addition to our work with the community health centers, we also work with private providers in rural areas. These physicians are struggling to survive in an environment that serves many rural elders. One of the providers we are working with has a patient load comprised of over 50% Medicare patients, and significant proportions of Medicaid and uninsured patients. Those of you who are aware of the cost of supporting a practice can well imagine the difficulties in doing so with this type of patient mix.

Today I would like to address several needs of the rural elderly in West Virginia which are likely comparable to other areas of the country. West Virginia has one of the highest percentages of elderly and the second highest rural population in the country. In addition, we rank very near the bottom of annual household incomes, and have a high rate of disabled residents. The state does not do well on many other social, economic and health indicators. It is estimated that we have over 100,000 elderly residents with chronic diseases such as diabetes, heart disease, asthma, and other respiratory diseases. These numbers are expected to increase. This will place an even greater burden on our already stressed health care system.

For the past several years, my office has been working with rural providers to change the way health care is delivered. We have worked extensively to change the care environment from one of responding to every patient as an acute care case, to one of treating the patient, where appropriate, as a chronic care patient. This requires a change in the way providers care for their patients. One of the most effective ways to initiate this process has been through the introduction of an electronic patient registry, with particular focus on chronic disease patients. The use of this technology is beginning to have the desired impact, but there are some limitations. One such limitation is the increased

resources needed to care for a chronic disease patient, at least initially. With a chronic disease patient, it is important to educate the patient and empower them to better manage their condition. This is most effective in settings that have patient education resources. We have critical shortages of educators that can teach these patients. This is a burden that we can not reasonably put on the providers. There are two recommendations that can help address this need. First, increase the reimbursement options for caring for chronic disease patients. The providers need to spend more time initially with the patient to develop an appropriate disease treatment and management plan. Second, increase the reimbursement options for midlevel educational providers. More flexibility in resource allocation is needed.

Although many providers are opting to use electronic medical record systems, there is still much work to be done in this arena. If the Medicare system can move towards the "pay-for-performance" model, more providers will be adapting better technology to monitor their performance-electronic medical records.

In my work with rural providers, I find many of these professionals highly motivated, but often over-worked and poorly compensated. One must find ways to help them be more efficient, but that in itself is not enough. In a recent study, it was found that nearly 50% of the physicians surveyed stated that they did not follow the most current guidelines for care because they did not know what they are. We need to add more resources to keep our provider workforce up to date on changes in health care protocol and delivery. We also need additional resources for programs such as CDC's Prevention Research Centers. These centers are charged with applying research to practice settings. Although we are making some remarkable discoveries in health care which are continually being disseminated, it is a lengthy process before these modifications (changes) are finally incorporated into every day provider practice.

Although there are many other recommendations that I could make, I will stop with these few. I appreciate the opportunity to present my ideas and experiences to this group. I hope together we can continue to make progress in the care of the rural elderly throughout the country.

Thank you.